



Orthopedic & Sports Medicine Specialists (OSMS)
Authorization for Release of Patient Identifiable Health Information

Patient Name: _____

Patient DOB: _____

I authorize the use or disclosure of the above named individuals health information as described below. I understand that I have the right to refuse to sign this authorization. OSMS is authorized to send and to receive the records.

The following individual(s) or organization(s) is authorized to SEND the records:

Name, Address, Fax & Phone number for individual or organization authorized to RECEIVE the records:

If OSMS is to receive the records:

2223 Lime Kiln Rd Ste 1 Phone: 920.430.8113
Green Bay, WI 54311 Fax: 920.430.8122

Information that may be released (check all that apply):

- Office Notes Operative Reports Therapy/Test Results Radiology CD/Report
 Any Disability/FMLA Information
 Information relating to mental health, alcohol or drug abuse or developmental disability
 HIV test results (according to Wis. Stat. 252.15 I have the right to request a list of releases made of my HIV test results without my consent),

This authorization is to remain in effect for one year or unless otherwise noted _____

Specific date range you would like released: _____

Signature of Patient or Personal Representative, person authorized
relationship, legal authority by patient or other legal authority

Date

Right to inspect or copy the information to be used or disclosed: I understand that I have the right to inspect or copy the information used or disclosed in the authorization. I can contact OSMS Privacy Officer.

Right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I will receive a copy of this signed authorization.

Redisclosure of information by recipient: I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about the disclosure of my health information, I can contact OSMS Privacy Officer at 2223 Lime Kiln Rd Green Bay WI 54311 or 920.430.8113.

Prohibition of Conditions: OSMS may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.

Right to Revoke Authorization: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to OSMS. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that if OSMS uses this authorization for marketing activities, I will be informed if they receive any direct or indirect remuneration related to the use or disclosure of my protected health information.